



HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164)****

****1. Authorization****

I, (patient's name) _____ authorize the staff at **Waypointe Internal Medicine, P.C.** to use and disclose the protected health information described below to

(individual(s) seeking the information and their phone number)

****2. Effective Period****

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

****3. Extent of Authorization****

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

b. I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Date: _____ **Signature of patient:** _____

Signature of Patient's Legal Representative (Guardian): _____

Relationship of patient's legal representative to the patient:

Spouse Father Mother Daughter Son Other: _____